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110TH CONGRESS
1ST SESSION

# H. R. 2749

To amend title XVIII of the Social Security Act to provide for a transition to a new voluntary quality reporting program for physicians and other health professionals.

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IN THE HOUSE OF REPRESENTATIVES

JUNE 15, 2007

Mr. GORDON of Tennessee (for himself and Mr. SHADEGG) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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# A BILL

To amend title XVIII of the Social Security Act to provide for a transition to a new voluntary quality reporting program for physicians and other health professionals.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the "Voluntary Medicare Quality Reporting Act of 2007".

**SEC. 2. FINDINGS.**

(a) FINDINGS.—Congress makes the following findings:

(1) The health care system of the United States is the world's most advanced health care system and delivers health care according to the highest quality standards. Physicians and other health professionals are committed to providing the highest quality of health care to beneficiaries under the Medicare program.

(2) Physicians have been actively engaged with the American Medical Association's Physician Consortium for Performance Improvement in the development of evidence-based and clinically valid measures in order to improve the quality of health care and have also worked closely with the Centers for Medicare & Medicaid Services ("CMS") in assuring the successful implementation of the Physician Voluntary Reporting Program ("PVRP") developed to measure and evaluate quality of health care.

(3) Physicians are actively collaborating with consensus organizations in their efforts to—

(A) improve the quality of health care through the specification of quality measures for services; and

(B) develop a rational system for collecting, aggregating, and reporting data across numerous public and private insurance programs in the least burdensome way.

(4) Quality measures for covered professional services (as defined in section 1848(k)(3)(A) of the Social Security Act (42 U.S.C. 1395w–4(k)(3)(A)) must be—

(A) evidence-based and clinically valid;

(B) regularly updated to reflect current medical practice;

(C) specialty specific; and

(D) developed by relevant medical and other health professional specialty societies with expertise in the area of health care involved.

(5) All quality measures for covered professional services (as so defined) should be pilot-tested in a variety of practice settings and across all relevant medical and other health professional specialties before they are included in a value-based purchasing system for such services.

(6) Physicians must be actively engaged in all aspects of the development and implementation of an effective quality reporting and value-based purchasing system for covered professional services (as

so defined). The development process for such system must be transparent to all physicians and adhere to a consistent set of rules.

(7) Any effective quality reporting system for covered professional services (as so defined) must recognize the actual health information technology and administrative costs physicians and other health professionals incur for participating in the system.

(8) Any quality reporting program for covered professional services (as so defined) should focus on meaningful improvements in patient care rather than requiring physicians to report for the sake of reporting.

(9) Most physicians and other health professionals have not had any experience in quality reporting and lack the necessary health information technology and administrative infrastructures to participate in a value-based purchasing system for physicians' services.

(10) The 6-month program under section 1848(k) of the Social Security Act (42 U.S.C. 1395w–4(k)), as added by section 101(b) of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432; 120 Stat. 2975), the 2007 Physician Quality Reporting Initiative ("PQRI"),

does not provide a sufficient amount of time to test and evaluate the appropriateness and effectiveness of this new reporting system. Therefore, it is premature to implement a permanent Medicare quality reporting system for physicians in 2008.

**SEC. 3. TRANSITION TO NEW VOLUNTARY MEDICARE QUALITY REPORTING PROGRAM.**

(a) EVALUATING THE TRANSITIONAL QUALITY REPORTING SYSTEM ESTABLISHED FOR 2007.—

(1) EVALUATION.—The Secretary of Health and Human Services shall evaluate the quality reporting system under paragraph (1) of section 1848(k) of the Social Security Act (42 U.S.C. 1395w–4(k)) (as added by section 101(b) of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432)), as applied for 2007 using the quality measures described in paragraph (2)(A) of such section to determine the following:

(A) The extent to which such quality measures were valid, clinically relevant, practicable, and not overly burdensome.

(B) The percentage of eligible professionals (as defined in paragraph (3)(B) of such section) in each category of eligible professionals de-

scribed in such paragraph that had such quality measures to report for such year.

(C) The rate of participation in such quality reporting system of eligible professionals described in subparagraph (B) in each such category.

(D) The average administrative costs of medical practices of such eligible professionals for reporting such quality measures, as it relates to the size of such practices.

(2) REPORT.—Not later than June 1, 2008, the Secretary of Health and Human Services shall submit to Congress a report containing the findings of the evaluation under paragraph (1).

(b) TRANSITIONAL QUALITY REPORTING AFTER DECEMBER 31, 2007, AND BEFORE IMPLEMENTATION OF NEW VOLUNTARY MEDICARE QUALITY REPORTING PROGRAM.—

(1) IN GENERAL.—Section 1848(k)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(k)(3)(B)) is amended to read as follows:

"(B) FOR 2008 AND 2009.—Eligible professionals may continue to report to the Secretary quality measures specified under subparagraph (A) after December 31, 2007, and before De-

cember 31, 2009, in order for the Secretary to refine systems for reporting quality measures.".

(2) PROHIBITING USE OF PHYSICIAN ASSISTANCE AND QUALITY INITIATIVE FUND FOR QUALITY REPORTING BONUS PAYMENTS IN 2008.—Section 1848(l)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(l)(2)(B)), as added by section 101(d) of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432), is amended by adding at the end the following new sentence: "The Secretary shall not expend from the Fund any amounts for bonus incentive payments for quality reporting of data on quality measures with respect to services furnished during 2008.".

**SEC. 4. THE VOLUNTARY MEDICARE QUALITY REPORTING PROGRAM.**

(a) IN GENERAL.—Section 1848(k)(2) of the Social Security Act (42 U.S.C. 1395w–4(k)(2)) as added by section 101(b) of Division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432; 120 Stat. 2975), is amended by adding at the end the following new subparagraph:

"(C) FOR 2010 AND SUCCEEDING YEARS.—

"(i) IN GENERAL.—For purposes of reporting data on quality measures for cov-

ered professional services furnished during 2010 and during succeeding years, the quality measures specified under this paragraph for covered professional services are quality measures the Secretary has selected in accordance with this subparagraph as part of the rulemaking process for payments under this section for 2010 and succeeding years, respectively.

"(ii) CHARACTERISTICS OF MEASURES.—The quality measures selected under clause (i) shall—

"(I) include a mixture of structural measures, process measures, and outcomes measures (as such terms are defined in clause (v));

"(II) be evidence-based and clinically valid;

"(III) be relevant to physicians, other eligible professionals, and individuals entitled to benefits under part A or enrolled under this part; and

"(IV) include measures that capture patients' assessments of clinical care provided.

"(iii) FAIRNESS.—The selection of quality measures under this subparagraph shall be conducted (and such quality measures shall be applied) in a manner that—

"(I) takes into account differences in individual health status;

"(II) takes into account an individual's compliance with health care orders;

"(III) does not directly or indirectly encourage patient selection or deselection;

"(IV) does not penalize eligible professionals who furnish services to individuals entitled to benefits under part A or enrolled under this part who are frail, low-income, of racial or ethnic minority groups, or of limited English language proficiency;

"(V) reduces health disparities across groups and areas;

"(VI) uses appropriate statistical techniques to ensure valid results; and

"(VII) assures that the Secretary is able to process data for the quality

measures as written by the individual or organization that developed the measure.

"(iv) SELECTION PROCESS FOR MEASURES TO BE REPORTED.—The measures selected under clause (i) for 2010 (and each succeeding year) shall be measures that have been published by the Secretary in the Federal Register not later than November 1 before the year as endorsed quality measures that are applicable to covered professional services during the year. For purposes of this subparagraph, the Secretary may publish quality measures for 2010 (or a succeeding year) in the Federal Register only if such measures are selected and endorsed as follows:

"(I) RECOMMENDATIONS FOR CLINICAL AREAS.—Not later than October 1, 2008 (and each succeeding October 1), the Secretary shall request, through notice in the Federal Register (without comment period), each physician specialty organization, each other eligible professional organi-

zation, and each quality improvement organization to submit to the Physician Consortium for Performance Improvement of the American Medical Association (referred to in this subparagraph as the 'Consortium') by not later than December 31, 2008 (and each succeeding December 31), recommendations of clinical areas for the development of quality measures for purposes of this subparagraph. Not later than December 31, 2008 (and each succeeding December 31), the Secretary shall also submit to the Consortium recommendations of clinical areas for the development of such quality measures.

"(II) SELECTION OF CLINICAL AREAS.—Not later than March 31, 2009 (and each subsequent March 31), the Consortium is requested to submit to the Secretary the recommendations described in subclause (I).

"(III) DEVELOPMENT OF PROPOSED QUALITY MEASURES.—Not later than June 1 of each year (beginning with 2009), the Consortium, in collaboration with physician specialty organizations and other eligible professional organizations, is requested to develop proposed quality measures for each clinical area identified under subclause (I). Such measures shall meet the requirements of clauses (ii) and (iii).

"(IV) ENDORSEMENT OF QUALITY MEASURES.—Not later than June 15 of each year (beginning with 2009), the Consortium is requested to submit the proposed quality measures developed under subclause (III) to a consensus organization for endorsement. Not later than September 30 of each year (beginning with 2009), the consensus organization is requested to submit to the Secretary the quality measures that have been endorsed by the consensus organization.

"(v) DEFINITIONS FOR TYPES OF MEASURES.—In this subparagraph:

"(I) STRUCTURAL MEASURE.—The term 'structural measure' means a measure that reflects the organizational, technological, and human resources infrastructure of a system necessary for the delivery of quality health care (such as the use of health information technology for submission of measures).

"(II) PROCESS MEASURE.—The term 'process measure' means a measure associated with the practice of health care or the furnishing of a service that is known to be effective.

"(III) OUTCOME MEASURE.—The term 'outcome measure' means a measure that provides information on how health care affects patients.

"(vi) CONSENSUS ORGANIZATION DEFINED.—In this subparagraph, the term 'consensus organization' means an organization, such as the National Quality Forum, that the Secretary identifies as—

"(I) having experience in using a process for reaching a group consensus with respect to quality measures relating to the performance of those providing health care services; and

"(II) including in such process practicing physicians, practitioners with experience in the care of the frail elderly and individuals with multiple complex chronic conditions, organizations and individuals representative of the specialty involved, individuals entitled to benefits under part A or enrolled under this part, experts in health care quality, individuals with experience in the delivery of health care in urban, rural, and frontier areas and to underserved populations, and representatives of the Secretary.".

(b) USE OF REGISTRY-BASED REPORTING.—Section 1848(k) of the Social Security Act (42 U.S.C. 1395w–4(k)) as added by section 101(b) of Division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432; 120 Stat. 2975) is amended to read as follows:

"(4) USE OF REGISTRY-BASED REPORTING.—As part of the process for reporting quality measures under subparagraphs (B) and (C) of paragraph (2), the Secretary shall address a mechanism whereby an eligible professional may provide data on quality measures through an appropriate medical registry, as identified by the Secretary. The Secretary shall require that any such mechanism be for purposes of reporting data only to the Secretary. The Secretary shall treat such data as confidential and shall not make such data available to any other party or person. Any data obtained by the Secretary under this paragraph shall not be subject to discovery or admitted into evidence in any Federal or State civil judicial or administrative proceeding.".

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